Commonwealth of Virginia Health Benefits Program
Extended Coverage Enrollment Form

To enroll or make eligible changes, complete the applicable parts of this Extended Coverage Enrollment Form, and **return to the appropriate agency Benefits Administrator**. See the Benefits Administrator or the Department of Human Resource Management's (DHRM) Web site at **www.dhrm.virginia.gov/compandbenefits.html** for complete Extended Coverage information.

PART A: Enrollee Information

PLEASE PRINT

Name _____ Social Security Number _____-_____-_____
First Name M.I. Last Name

Address _____
Street City State Zip

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex: ☐ Male ☐ Female Date of Birth _____
MM/DD/YYYY

PART B: Reason(s) For Submitting Enrollment Form

I. ☐ **Enroll in Extended Coverage** (Initial Enrollment) Date Of Qualifying Event _____

Qualifying Event (Check one)

☐ Termination of Employment
☐ Divorce*
☐ Reduction in Hours (includes leave without pay and VSDP long-term disability)
☐ Loss of Dependent Eligibility*
☐ Death of the Employee

**If this form is to serve as notice of the event, documentation required by your initial General Notice must be attached.*

Once enrolled, you may change your plan and type of membership during the annual Open Enrollment or within 31 days of a consistent qualifying mid-year event which permits an election change outside Open Enrollment.

II. ☐ **Open Enrollment Change**

III. ☐ **Military Leave**

IV. ☐ **Changes Outside Open Enrollment**

Dependent(s) affected by election change:

Add Dependent (Name) _____

Remove Dependent (Name) _____

Qualifying Mid-Year Events Date of Event _____

Employment Change
☐ Employee begins leave without pay or family medical leave (49)
☐ Employee returns from leave without pay or family medical leave (50)
☐ Spouse or covered child gains employer eligibility (including switching from part-time to full-time employment) (28)
☐ Spouse or eligible child loses employer eligibility (including switching from full-time to part-time employment) (13)
☐ Spouse begins leave without pay (64)
☐ Spouse ends leave without pay (63)

Legal Marital Status Change
☐ Marriage (07)
☐ Divorce (10)
☐ Death of spouse (08)

Judgments, Decrees or Orders
☐ Judgment, decree, or order allowing another party to cover your child(ren) (67)
☐ Judgment, decree or order requiring coverage of a child(ren) (71)

Medicare or Medicaid Change
☐ Dependent gaining eligibility for Medicare or Medicaid (66)
☐ Losing eligibility for Medicare or Medicaid (09)

Number of Eligible Family Members Change
☐ Adoption (16)
☐ Birth (15)
☐ Covered child ceases to be eligible (exceeds plan's age limit, marries, becomes self-supporting, etc.) (38)
☐ Death of a covered child (17)
☐ Permanent custody granted (72)

Changes Due to Special Circumstances
☐ HIPAA special enrollment due to loss of other group coverage (70)
☐ Losing eligibility under another government-sponsored plan (76)
☐ Employee or dependent moves in or out of a plan's service area (05)

Cost and/or Coverage Changes
☐ Day care provider or cost of day care change (for Dependent Care FRA only) (61)
☐ Open Enrollment or significant change under an employer's plan (62)

PART C: Health Coverage

I. TYPE OF MEMBERSHIP (Check one)

☐ Single ☐ Enrollee Plus One ☐ Family

Is this a change in membership? ☐ Yes ☐ No

II. HEALTH PLAN

Be sure to use providers or facilities that participate in your plan's provider networks.

(Check One)

Self Funded Statewide Plans

Administered By the State Health Benefits Program

❑ COVA HDHP [High Deductible Health Plan] (CHD)

❑ COVA Care Plan (CC0)
❑ COVA Care + Out-of-Network (CC1)
❑ COVA Care + Expanded Dental (CC2)
❑ COVA Care + Out-of-Network + Expanded Dental (CC3)
❑ COVA Care + Vision + Hearing + Expanded Dental (CC4)
❑ COVA Care + Out-of-Network + Vision + Hearing + Expanded Dental (CC5)

Regional Fully Insured HMO (Northern Virginia)

❑ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO

**Note: Kaiser plan members must select a primary care physician.*

☐ Medicare Coordinating Plan: Plan Name _____

III. FAMILY MEMBERS TO BE COVERED (list all)

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF= other female child* OM=other male child*

NAME PLEASE PRINT (include last name if different)	BIRTHDATE MM/DD/YYYY	SOCIAL SECURITY NUMBER	RELATIONSHIP CODE
Spouse			
Children			

If you need more space, list additional children on a separate sheet of paper and attach to this Form.

*Attach explanation. Eligibility must be verified by your Benefits Administrator.

IV. PAYING PREMIUMS

Your premium is always paid on an after-tax basis. Monthly Premium Amount $_____

PART D: Certification

ENROLLEE STATEMENT: I want to enroll in Extended Health Care Coverage and understand that I will be billed directly. Once enrolled, I understand that changes may only be made at Open Enrollment or with certain qualifying mid-year events (see Part B) when the changes are consistent with the events. I understand that my health premiums are subject to change. I am aware that the Commonwealth reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that non-payment of premium will result in cancellation of coverage per the provisions of the Public Health Service Act and that claims will not be processed during the defined grace period. Further, I understand that no claims will be processed for services during months for which premium payment in full has not been received.

CERTIFICATION/AUTHORIZATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name _____ Social Security Number _____

Sign Here _____ Date _____

Agency Approval/Verification

Number of months for Extended Coverage: _____

I certify that I have reviewed this Extended Coverage Enrollment Form and that it is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date Received _____ MM/DD/YYYY

Print Name and Title_____ Phone No. _____

Agency Name _____ Agency No. _____ Effective Date _____ MM/DD/YYYY